DRAFT EVALUATION & MANAGEMENT
DOCUMENTATION GUIDELINES
(June 2000)

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical

services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:

   - the chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care; and
   - date and a verifiable legible identity of the health care professional who provided the service.

3. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.

4. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

8. An addendum to a medical record should be dated the day the information is added to the medical record and not dated for the date the service was provided.

9. Timeliness: A service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

10. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three ***key*** components of E/M services and for visits which consist predominately of counseling or coordination of care. The

three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of the coding reference, Current Procedural Terminology (CPT) has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service.
Documentation guidelines are identified by the symbol *DG*.

The descriptors for the levels of E/M services recognize seven components that are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) details of the mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive.) Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgement and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief (1 -3)	N/A	N/A	***Problem Focused***
Brief (1 -3)	Brief (1 -2)	Pertinent (1 of 3)	***Expanded Problem Focused***
Extended (4+)	Extended (3 - 8)	Complete (2 of 3 or 3 of 3)	***Detailed***
Extended (4+)	Complete (9+)	Complete (2 of 3 or 3 of 3)	***Comprehensive***

- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

    - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
    - *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: The physician should document efforts made to obtain a history from the patient, accompanying family members, friends or attendants or emergency personnel (e.g., paramedics) or available medical records (e.g., previous hospital records, nursing facility records, ambulance records). It is rare that no history will be available. Any history obtained will be evaluated according to the guidelines.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It should provide pertinent details about the reason for the encounter. Types of details include:

- For symptoms: location, quality, severity, duration, timing, context, modifying factors including medications, associated signs and symptoms etc.
- For follow up of a previously diagnosed problem: changes in condition since the last visit, compliance with the treatment plan etc.
- For patients on multiple medications or whose primary reason for the visit is for medication management: review of compliance, effectiveness of medications, side-effects and complications from medications, verification of medication name, dosage and frequency.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- *DG: A **brief** HPI consists of: documentation of the chief complaint(s) or reason(s) for the encounter as well as 1 - 3 pertinent details about at least one presenting problem*

- *DG: An **extended** HPI documents the chief complaint(s) or reason(s) for the encounter as well as 4 or more details about at least one presenting problem.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following are recognized:

- **CONSTITUTIONAL SYMPTOMS** (e.g., fever, weight loss)

- **ORGAN SYSTEMS**
  - Ophthalmologic
  - Otolaryngologic
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breast)
  - Neurological
  - Psychiatric
  - Endocrine
  - Hematologic/Lymphatic
  - Allergic/Immunologic

- *DG: A **brief** ROS inquires about the system(s) directly related to the presenting problem(s)/ complaint(s). For example: (i) GI system for chief complaint of diarrhea; (ii) Pulmonary and Cardiac systems for chief complaint of chest pain. This overlaps with HPI. Generally a brief ROS consists of 1 or 2 organ systems.*

- *DG: An **extended** ROS includes a brief ROS as well as a review of additional organ system(s); generally an extended ROS consists of 3-8 organ systems including the system directly related to the presenting problem(s)/complaint(s).*

- *DG: A **complete** ROS includes a review of 9 or more organ systems including the system directly related to the presenting problem(s)/complaint(s).*

Documenting positive and negative findings: All positive findings must be described; negative findings do not need to be individually documented except as appropriate for patient care: a notation indicating a system was negative is sufficient; the name of each system reviewed must be documented. For example:

(i) the following notations are acceptable:
- "Pulmonary: cough x 4 weeks, otherwise negative"
- "Cardiac: negative"
- "ROS: cardiac, pulmonary, GI, GU, endocrine all negative"

(ii) the following notations are unacceptable:
- "ROS: negative"
- "Pulmonary: positive"
- "All systems negative"

PAST, FAMILY AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (e. g. the patient's past experiences with illnesses, operations, injuries, medications, compliance, and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH .*

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. **DOCUMENTATION OF EXAMINATION**

The levels of CPT E/M services are based on four types of examination that are defined as follows:

- ***Problem Focused*** -- a limited examination of the affected body area or organ system.
- ***Expanded Problem Focused*** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- ***Detailed*** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- ***Comprehensive*** -- a general multi-system examination or complete examination of a

single organ system.

- *DG: For documentation purposes, problem focused and expanded problem focused examinations are similar and are designated as a "brief" examination.*

For purposes of examination, the following are recognized:

A. BODY AREAS

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

B. ORGAN SYSTEMS

- Ophthalmologic
- Otolaryngologic
- Cardiovascular
- Respiratory
- Endocrine
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Hematologic/Lymphatic
- Allergic/Immunologic

C. CONSTITUTIONAL

(e.g., vital signs, general appearance) A description of a minimum of 3 findings is comparable to one body area or organ system.

- *DG: The medical record for multi system examinations should be documented as follows: (1) a brief examination should include findings from 1 or 2 body areas or organ systems, (2) a detailed examination should include findings from 3 to 8 body areas or organ systems, and (3) a comprehensive multi-system examination should include findings from 9 or more of the 7 body areas or 13 organ systems, or at least 3 constitutional findings that are comparable to 1 body area or organ system .*

- *DG: For brief, detailed, and comprehensive single system examinations refer to the specialty specific single system vignettes in appendix A for appropriate documentation.*

The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation*

of "abnormal" without elaboration is insufficient.

- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*

- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

In order to determine the level of decision making for an encounter, the medical record should include documentation of an assessment and plan for each problem evaluated during the encounter. The assessment and plan for each problem should include documentation of (1) the status/severity/urgency of the problem(s) and the risk of complications and deterioration, (2) the amount and complexity of data reviewed and differential diagnosis(es), (3) the diagnostic and therapeutic tests, procedures and interventions ordered and the treatment plan.

A. Low Complexity Medical Decision Making

Typically, the problem(s) addressed will (1) be of low severity, low urgency and low risk of clinical deterioration and complications, (2) have a limited differential diagnosis and limited review of additional data, (3) have straightforward diagnostic and/or therapeutic interventions, and a straightforward treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for low complexity.

B. Moderate Complexity Medical Decision Making

Typically, the problem(s) addressed will (1) be of moderate severity with a low to moderate risk of clinical deterioration, (2) require review of a detailed amount of additional information with an extended differential diagnosis, (3) require complicated diagnostic and/or therapeutic intervention, with a complicated treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for moderate complexity.

C. Highly Complex Medical Decision Making

Typically, the problem(s) addressed will (1) be of high severity with a high risk of complications and clinical deterioration, (2) require review of an extensive amount of additional information with an extensive differential diagnosis, (3) require highly complex multiple diagnostic and/or therapeutic interventions, with a highly complex treatment plan. For the purpose of documentation two of these three elements must either meet or exceed the requirement for highly complex medical decision making.

The following is a more detailed discussion of several of the elements of medical decision making:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;

- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and

- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

    - *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

    - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible", "probable", or "rule out" (R/O) diagnoses.*

- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications. This is particularly important for patients on multiple medications or whose primary reason for the visit is for medication management*

- *DG: When consultations are requested or advice sought, the record should indicate to whom or where the consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or*

performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.

- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

- *DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

- *DG: The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: Comorbidities/underlying diseases or other factors (e.g. the number and type of medications) that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The table below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must either meet or exceed the requirements for that type of decision making.**

TABLE

Severity/Urgency of the problem(s) and Risk of Complications and Deterioration	Differential Diagnoses and Amount/Complexity of Data Reviewed	Treatment Plan including diagnostic and therapeutic tests, procedures and interventions	Type of Decision Making
Low	Limited	Straightforward	Low
Moderate	Detailed	Complicated	Moderate
High	Extensive	Highly Complex	High

Please refer to the specialty specific medical decision making vignettes in appendix B for guidance in using this table.

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: The total length of time of the encounter (face-to-face or floor time, as appropriate) and a full description/explanation of the counseling and/or activities coordinating care must be documented in the medical record.*

- *DG:* Performance of a history and physical examination, although not required at each instance of counseling/coordination of care, should be referred to when appropriate.

- *DG:* Medical decision making associated with this service must be documented as part of the counseling and/coordination of care.